| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005012 | A. BUILDING: _____ B. WING _____ | 10/22/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT JOSEPH REGIONAL MEDICAL CENTER | 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>The visit was for investigation of a State hospital complaint.<br><br>Complaint Number:<br>IN 00130187<br>Substantiated; no deficiencies related to allegations are cited<br><br>Survey Date: 10-21 and 10-22-13<br><br>Facility Number: 005012<br><br>Surveyor: Brian Montgomery, RN<br>Public Health Nurse Surveyor<br><br>Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.5-1, Dietetic services, Indiana Hospital Licensure Rules.<br><br>QA: claughlin 11/01/13 | S 000 | | |